Senate Fiscal Agency

State Notes

TOPICS OF LEGISLATIVE INTEREST

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EPIC: PROGRAM RECAP AND CURRENT STATUS

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After a long, and some would say arduous journey, the Elder Prescription Insurance Coverage (EPIC) program opened its doors for business on October 1, 2001. The EPIC program was based on a concept first proposed in the spring of 1999 by Senator Harry Gast, Chair of the Senate Appropriations Committee, with the assistance of Senator John J. H. Schwarz, M.D., Vice Chair of that Committee.

During the period that the Senators were formalizing the EPIC concept, many senior citizens (meaning persons age 65 and older, for this purpose) had only limited or no outpatient prescription coverage. This was especially true for low-income seniors. Medicare, the primary source of medical coverage for seniors, has an exceedingly limited outpatient prescription component. While seniors can purchase a "Medigap" policy that includes prescription coverage, such coverage has high deductibles and copayments as well as low annual expenditure caps. Perhaps more significant is that, these policies are relatively expensive, costing between $700 and $1,200 more annually than the same policy without prescription coverage.

In Michigan, besides Medicare and Medigap, seniors' prescription assistance was limited to a couple of State-funded or locally based programs. For very low-income seniors with limited assets, Medicaid also was available, though many of these individuals were in long-term care facilities where outpatient prescription coverage was not an issue.

The existing State-funded programs, the senior prescription tax credit and the Michigan Emergency Pharmaceutical Program for Seniors (MEPPS), did provide some relief for prescription costs of eligible seniors. However, the eligibility criteria and assistance delivery process were less than optimal. The latter program, MEPPS, was, as stated, an "emergency" program. The basic criteria limited potential coverage to individuals or couples with incomes at or below 150% of poverty with no other prescription coverage. In addition, the precipitating event for filling or refilling one or more prescriptions was a cost in excess of 10% or 8% (for individuals or couples, respectively) of that month's income. The eligible person would be given a voucher that would cover the cost of the prescription(s) at a retail pharmacy. The major problem with this program was that, due to budget constraints, it limited access to only three episodes per year except under the most dire of circumstances.

The senior prescription tax credit program did offer assistance to a larger cohort of the elderly, but still had its own shortcomings. Ostensibly open to all seniors at or below 150% of poverty, these persons would have to spend at least 5% of their income (regardless of income level) on prescriptions during a tax year just to meet the basic program criteria. If a senior spent more than 5% of his or her income, then the person would be eligible for the tax credit, but only for the next $600 of prescription expenses. Any spending over that amount came out of the senior's pocket. One additional shortcoming of the tax credit program was that after filing for the credit, a senior would not actually receive

reimbursement until the August following the close of the tax year during which he or she had made the expenditures. All in all, these programs did provide some assistance for 30,000 to 40,000 claimants/recipients at an annual cost of between $20 million and $26 million.

It was within this context (and a decision to use $30 million or so of the new tobacco settlement dollars for this purpose) that EPIC was born. As mentioned above, it took some time and doing before the EPIC statute was signed into law as Public Act 499 of 2000, with an effective date of October 1, 2001. However, the final EPIC program is not considerably different from what was proposed by Senators Gast and Schwarz. It was originally intended that all elderly persons at or below 200% of poverty, without other prescription coverage (but excluding a Medigap policy with a prescription option), would be eligible for EPIC. Unlike either MEPPS or the tax credit program, cost-sharing (in the form of a yearly premium) would be done on a sliding scale that varied by income level. For example, for seniors at or below 100% of poverty (for tax year 2001: $8,590 for single persons and $11,610 for couples), the premium for a year would be $85.90 for a single person and $116.10 for a couple, or 1% of income. At 150% of income, the premium would be 3% of income, and the yearly premium would not reach 5% until an enrollee's income was over 175% of poverty. As noted previously, the senior prescription tax credit program excluded all elderly persons with incomes over 150% of poverty and, for those who qualified, the benefit did not begin until a senior had already spent 5% of his or her income on prescription medications - regardless of whether that income was 150% or 50% of poverty. The only other cost envisioned for EPIC was an annual $25 application fee.

As is the case with most legislation, the EPIC bill was modified to meet various concerns before it became law. As the original version of the Senate bill was making its way through the committee process, the House began to draft its own version of how a State-financed senior prescription program should work. The major point of difference revolved around the issue of "cost-sharing". The Senate version used a "premium" model. That is, the premiums that were paid by the enrollees would help to offset the program's costs. In addition, like almost any insurance model, some enrollees' expenses would be less than the premiums paid, while other enrollees' expenses would cost more than what they paid in premiums. In effect, low users would subsidize high users. The House wanted a cost-sharing model that better reflected the cost experience of each individual. House members felt this could best be accomplished through a "copayment" as opposed to a premium. As the maximum monthly copayment was based on one-twelfth of what the yearly cost of the premium would have been, the House's plan would have a fiscal effect similar to that of the Senate's approach, on an individual-by-individual basis. However, it would not have the same global effect because there was no subsidization of high users by low users. The House's copayment model replaced the Senate's premium model in the enacted EPIC statute.

The third party to those negotiations was the Engler Administration, which had expressed grave reservations about EPIC from the time that the administration had first heard about the proposed program. Its primary concern was that the cost estimates were too low. Other

questions that the administration found problematic included: What safeguards could be implemented/developed to mitigate a possible overexpenditure? Would EPIC be seen as an "entitlement"? What would happen to EPIC if the Federal government enacted a similar program? As was the case with the House's concerns, the Senate's version of the bill was modified to address the issues raised by the administration (that is, short of not adopting EPIC at all). Some of the adjustments included establishing EPIC as the payer of last resort, specifying that EPIC is not an entitlement, limiting the benefits to the amount supported by the level of funds appropriated, and authorizing the administration to take corrective action such as requesting a transfer or supplemental or suspending further enrollments. All of these issues and others were accounted for in the final bill. Once EPIC was signed into law, the Department of Community Health (DCH) quickly submitted Requests For Proposals (RFPs) for the purpose of operating the EPIC program. In doing so, the DCH was able to begin sending applications to and then processing them from the first required coverage group, which consisted of those seniors who had used MEPPS at any time during the preceding 12 months.

By mid-August 2001, almost 13,000 applications had been mailed and a toll-free phone system to assist applicants was up and running. In addition, the DCH had been offering grants to 150 senior citizen centers and to all Area Agencies on Aging to assist in educating and filling out applications for those seniors who were eligible for EPIC from the first priority group. Starting in September 2001, seniors whose applications had been approved began receiving their EPIC membership cards. On October 1, 2001, the day after MEPPS officially came to an end, seniors began receiving their prescriptions from over 2,000 pharmacies enrolled in the EPIC program. On the same date, the emergency component of EPIC was implemented. This reflected the requirements of Section 4 of the EPIC Act, under which any senior who met the criteria of MEPPS could receive coverage under EPIC for up to 90 days.

During the same period, the DCH mailed over 33,000 EPIC applications to the second priority group, which consisted of individuals who had filed for the tax credit under the senior prescription tax credit program any time within the previous 12 months. As specified in the EPIC statute, enrollees from this group began receiving their prescriptions from participating pharmacies on December 1, 2001. At midnight on December 31, the senior prescription tax credit program was repealed. (However, the tax credit will continue to be payable for eligible seniors who had unreimbursed prescription expenses during tax year 2001.)

After six months of operation, it is still too early to make definitive statements about expenditure trends or to make qualitative assessments of the overall EPIC process, e.g., ease of application, simplicity of prescription purchases, and level of provider payments. This is partly because EPIC, by design, used a phased-in approach.

In addition, the Engler Administration is still concerned about the ultimate costs of the program and, therefore, has frozen enrollment at the first two priority groups. While the statute does allow the administration to freeze enrollment, the question is how long is it

reasonable to continue that freeze once it is shown that expenditures will not exceed appropriations in the current year.

One additional factor, which no one anticipated, has had a definite impact on aggregate expenditures: the extraordinarily low enrollment rate. As of the end of March 2002, fewer than 15,000 people had enrolled in the EPIC program, even though slightly more than 46,000 applications were sent to potential eligibles. The Department has sent out a follow-up letter to the MEPPS-eligible priority group to try to ensure that this group was aware of the EPIC program. Likewise, senior citizen centers and Area Agencies on Aging were given grants to help fund the education and application process. Department meetings with these entities were held during July and August to provide training.

One possible explanation for the low enrollment is that despite the best efforts of the Department and senior advocates, the target population is still not fully aware of what the EPIC program is. This may pertain more to the tax credit group, as the data seem to indicate that, during last October and November, around 65% of the people eligible for MEPPS enrolled in EPIC. Since it appears that the individuals eligible for the tax credit have not enrolled, it could be that these seniors believe that they had one of two options: either use the tax credit program or enroll in EPIC. (This, of course, is not the case, as both EPIC and the tax credit program can be used for the 2001 tax year.) The data, however, do not support this hypothesis; even though the enrollment deadline was extended until early February 2002, there was no significant growth in enrollment during January 2002.

Another possibility relates to income eligibility. Because the senior prescription tax credit has a basic income eligibility criterion (at or below 150% of poverty), one would think that the number of credits claimed in a preceding year would be a good indicator of how many seniors potentially eligible for EPIC would come from that group. However, an estimate following this line of reasoning may be less than valid. First, an interesting trend can be found in the number of credits claimed over time. For tax year 1989, 26,300 credits were claimed. There was a gradual increase in claims through tax year 1994, when they topped out at 39,500. Since then, the number of credits claimed declined to 29,146 for tax year 2000. Therefore, it would not be surprising to find a lower estimate today than just a few years ago.

The other part of this income-related estimate is the possibility that individual perceptions of what was countable income under the tax credit program are different than what is countable under EPIC. This does not mean that senior citizens were “cheating” when filing the tax credit form; it simply could be that filling out the EPIC application requires more thought as to what constitutes income. Both of these forms are on a single page, but the similarity stops there. On the tax credit form, one is asked to attest that his or her income is “X”. The EPIC form not only asks a similar question, but also provides a listing of 14 different categories of income and requires the filer to provide reasonable proof of each. Of the approximately 15,500 EPIC applications received so far, about 1.2% have been denied due to excess income, even though the applicants had filed a claim for the prescription drug credit in the preceding year. In addition, 16% of the EPIC applications

have needed additional information to determine eligibility, with the most common issue being proof of income. (Also, it appears that participants in the tax credit program have never been audited.)

One of the most plausible, though hardest to explain, reasons for the observed low enrollment rate is the fundamental nature of the population at hand. In other words, a sizable portion of senior citizens are low income, have a significant need for prescription medications, have limited or expensive third party coverage, and, as a result, have high out-of-pocket costs relative to their income. This is the operating model supported by conventional wisdom, and the "estimating" is simply associating the right numbers with the right variables. The Senate Fiscal Agency (SFA) estimate targeted expected out-of-pocket prescription costs adjusted for age, marital status, income, and prescription utilization. The base values came from the Medicare Current Beneficiary Survey (MCBS) from 1994 and 1996 adjusted for inflation into the future. The outcome was as expected: Lower income equates to higher out-of pocket costs relative to income. However, SFA research also indicated that there may be a greater level of third party coverage than is usually thought. The Engler Administration's estimate has been consistently higher than that of others, but it is generated from comparable Medicaid data. The administration's basic dollar results were no different than the SFA's: low income, high relative costs. It should be noted that the administration's outcome was rather predictable because it chose to assume a relationship between the EPIC program target population and a "comparable" Medicaid population. The problem is, almost by definition, the Medicaid population is very low income and has high health care utilization. In a non-Medicaid population, the latter variable may not correlate; the relationship may be the inverse in that one has already accounted for the high health care utilization as these low-income folks are already on Medicaid.

One final perspective to this estimating dilemma revolves around a 1999 study undertaken by Gross, et al.[1] Using data from the 1993 MCBS, Gross, et al. found that out-of-pocket health care expenses result in a significant burden on senior citizens in general, and on poor elderly persons in particular. Their finding that the elderly, on average, spend 19% of their income on medical care (rising to 35% for poor seniors), is similar to a 1996 study that used a different data set, but the same estimating methodology. As a result of these studies, there have been recommendations that the government do more to increase the financial protection against high out-of-pocket health care expenses for the elderly. The problem with these studies, according to Dana Goldman[2] of RAND Health, is that the

[1]Gross, D.J., L. Alecxih, M.J. Gibson, J. Corea, C. Caplan, and N. Brangan. 1999. "Out-of-Pocket Spending by Poor & Near-Poor Elderly Medicare Beneficiaries", Health Services Research, 34 (1,Part II); 241-54.

[2]Goldman, D.P. and Smith, J.P. "Methodological Biases in Estimating the Burden of Out-of-Pocket Expenses", Health Services Research, pp. 1357-1365, February 2001.

methodology used is wrong. In fact, it is so wrong, especially as applied to the poor elderly, that it "...distorts the real policy issues that exist in providing elderly Americans adequate protection against the possibility of significant medical expenses during their old age." The Senate Fiscal Agency believes that many of these types of studies do tend to assume the worst outcomes, which often results in exceedingly cautious behavior to the point that nothing meaningful gets accomplished.

If one were to describe the current status of EPIC in a single word, "stagnant" comes to mind. It is stagnant to legislators because all that was promised in the enabling legislation has not come to pass. It is stagnant to the administration and legislative analysts because EPIC's operating fiscal parameters are still unknown. Finally, it is stagnant for any number of elderly persons who are income-eligible but not currently enrolled in EPIC, and will not have the senior prescription tax credit program to fall back on. Nevertheless, the relatively few individuals who are enrolled in the EPIC program have an opportunity that neither MEPPS nor the tax credit program ever aimed to achieve.

In order to encourage more seniors to take advantage of that opportunity, the Legislature could consider various options, including the following:

- Instruct the DCH to undertake a survey of a statistically significant sample pulled from the universe of persons eligible for the former MEPPS and tax credit who received an EPIC application, but chose not to enroll in the EPIC program. The purpose of the survey would be to determine what factors resulted in their declining to enroll in EPIC.

- Require the DCH again to send out EPIC applications to all seniors eligible for the former MEPPS and tax credit who were on the original or adjusted mailing list and who have not as of yet applied for EPIC. The DCH also could establish a new two-month window during which applications would be accepted.

- If it still appears that enrollment in EPIC by the first two priority groups will remain low, the DCH could expand enrollment to all other elderly persons at or below 150% of poverty. The Department could randomly select a preset number of applications (say, 1,000 at a time) from this new pool and then wait for two or three months before selecting additional sets of applicants in order to assess the impact on expenditures the previous randomly selected enrollees have on program expenditures.

In closing, Gross expenditures for EPIC through the middle of April 2002 have been less than $10 million. As things currently stand, there is no possibility that the remaining $40 million will be spent by the end of this fiscal year. Given all the facts and circumstances surrounding EPIC, there seems to be little to lose by adjusting the application dam at this time. On the other hand, there is a potential for a significantly greater loss if the status quo is maintained and EPIC ultimately fails.